400-1
The CDHS issues Medi-Cal regulations, and these regulations are found in Title 22, California Code of Regulations (CCR). All further references, unless otherwise noted, are from the CCR. (§50005)

400-1A
For purposes of this decision, W&IC is the abbreviation for the Welfare & Institutions Code.

400-2
Hearings are to be conducted in accordance with regulations and procedures set forth by the California Department of Social Services (CDSS). Those regulations are set forth in Division 22 of the Manual of Policies and Procedures issued by the CDSS. (§50953)

400-3
The Director of the CDHS may develop an agreement with another agency to perform state hearings. The Department shall retain sole authority for decision-making on Medi-Cal issues. (§50953(c))

400-4
All requests for rehearing or reconsideration of cases involving Medi-Cal shall be acted upon by the Director. The Director shall grant or deny the request no earlier than 5 nor later than 15 working days after the request is actually received by the Department. If action is not taken within this period, the request for rehearing will be deemed denied. (§50953(c)(2))

400-5
The CDHS is the single state agency approved by the Secretary of the Department of Health and Human Services to administer the Medi-Cal program. (§50004(a))

The CDHS shall administer the Medi-Cal program in accordance with the following: (1) The State Plan under Title XIX of the Social Security Act. (2) Applicable State law, as specified in the Welfare & Institutions Code. (3) Medi-Cal regulations. (§50004(b))

400-6
Federal regulations provide as follows:

"The applicant or recipient, or his representative, must be given an opportunity to --

(a) Examine at a reasonable time before the date of the hearing and during the hearing:

(1) The content of the applicant's or recipient's case file; and

(2) All documents and records to be used by the State or local agency, the skilled nursing facility, or nursing facility at the hearing;

(b) Bring witnesses;

(c) Establish all pertinent facts and circumstances;

(d) Present an argument without undue interference; and

(e) Question or refute any testimony or evidence and cross-examine adverse witnesses."

(42 Code of Federal Regulations (CFR) §431.242)

400-7
Federal regulations provide as follows:

"(a) Hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing;

(b) The record must consist only of--

(1) The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;

(2) All papers and requests filed in the proceeding; and

(3) The recommendation or decision of the hearing officer.

(c) The applicant or recipient must have access to the record at a convenient place and time.

(d) In any evidentiary hearing, the decision must be a written one that--

(1) Summarizes the facts and;

(2) Identifies the regulations supporting the decision.

(e) In a de novo hearing, the decision must--

(1) Specify the reasons for the decision; and

(2) Identify the supporting evidence and regulations.

(f) The agency must take final administrative action within 90 days from the date of the request for a hearing.

(g) The public must have access to all agency hearing decisions subject to the requirements of Subpart F of this part for safeguarding of information."

(42 Code of Federal Regulations (CFR) §431.244)

400-8
Federal regulations provide, in pertinent part, that:

(b) A state plan must—

(1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and

(2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to—

(i) Administer or supervise the administration of the plan; and

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

(c) Determination of eligibility.

(1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is—

(i) The Medicaid agency; or

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia).

(2) The plan must specify whether the agency that determines eligibility for the aged, blind, or disabled is—

(i) The Medicaid agency;

(ii) The single State agency for the financial assistance program under Title IV-A (in the 50 States or the District of Columbia), or

(iii) The Federal agency administering the supplemental security income program under Title XVI (SSI). In this case, the plan must also specify whether the Medicaid agency or the Title IV-A agency determines eligibility for any groups whose eligibility is not determined by the Federal agency.

(e) Authority of the single State agency. In order for an agency to qualify as the Medicaid agency—

(1) The agency must not delegate, to other than its own officials, authority to—

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

(42 Code of Federal Regulations §431.10)

401-1
When an applicant has excess resources, counties must still complete eligibility determinations within the time limits set forth in §50177. If the applicant provides verification at a later date that excess property was spent on qualified medical expenses (up to three years from the date of the Notice of Action denying benefits), the county must rescind the denial if the applicant is otherwise eligible.

When billing may occur more than one year beyond the date of the service, the county shall complete and send a letter of authorization (MC 180) following the procedures in Medi-Cal Eligibility Procedures Manual §14E and §50746, and shall indicate that eligibility is granted as a result of court order (*Principe* v. *Belshé*).

(All-County Welfare Directors Letter No. 97-41, October 24, 1997)

404-1
Before a Notice of Action (NOA) is issued by the county to deny a new applicant Medi-Cal benefits, the county must ensure the NOA contains specific reasons for the denial action and the appropriate corresponding regulations. (All-County Welfare Directors Letter No. 97-48, November 18, 1997)

404-2

All notices of action denying eligibility based upon excess property must contain the following statement:

"IMPORTANT INFORMATION IF THIS NOTICE IS A DENIAL BECAUSE OF EXCESS PROPERTY AND YOU HAVE UNPAID MEDI-CAL BILLS: The MC 007 tells you about how this denial will be stopped if you use all of your excess property by paying medical bills that you owed during the month when you applied for Medi-Cal or after. This will not work if you wait more than three years. Ask your eligibility worker for an MC 007."

(All-County Welfare Directors Letter No. 97-41, October 24, 1997, p.8)

404-3
Following approval of Medi-Cal after a *Principe* v. *Belshé* spenddown, the county and applicant complete form MC 174. The county determines, in consultation with the applicant, whether any of the remaining medical bills paid by the applicant are to be applied to shares of cost for months during the application process. If not, or if only some of the remaining medical bills will be applied to the shares of cost, then the county shall provide the following information on the Notice of Action approving benefits:

"IMPORTANT INFORMATION ABOUT GETTING REFUNDS FROM YOUR PROVIDER: State law says that your provider has to give you back whatever you paid for a medical service if that provider gets money from Medi-Cal for the same service. Your provider cannot give you money back if you paid a medical bill with excess property to get below the property limit or if the money was part of your share of cost. Your MC 174 tells you about refunds. If you need another copy of your MC 174, ask your eligibility worker."

(All-County Welfare Directors Letter No. 97-41, October 24, 1997)

404-4
In addition to any notice mailed pursuant to §§50179, 53261, 53452, 56261, or 56452, each beneficiary shall be informed by notice, in writing, of the right to a fair hearing when there is:

(1) Any action, other than approval, including but not limited to deferral or denial, taken by the Department or a Medi-Cal managed care plan on a request by a provider for any medical service.

(2) Any intended action by the Department or a Medi-Cal managed care plan to terminate or reduce any medical service.

(§51014.1(a))

404-4A

Except as provided in §51014.1(d), notice of intended action to reduce or terminate authorization for a medical service (i.e., a service that is subject to prior authorization) prior to expiration of the period covered by the authorization shall be mailed by the Department or by the Medi-Cal managed care plan to the beneficiary at least 10 days before the effective date of action. The notice shall include:

(1) A statement of the action the Department or Medi-Cal managed care plan intends to take.

(2) The reason for the intended action.

(3) A citation of the specific regulations or Medi-Cal managed care plan authorization procedures supporting the intended action.

(4) An explanation of the beneficiary's right to request a fair hearing for the purpose of appealing the Department's or Medi-Cal managed care plan's decision.

(5) An explanation of the procedure to request a hearing.

(6) An explanation of the circumstances under which a medical service shall be continued if a hearing is requested.

(§51014.1(c) and (i))

404-4B
Continued medical assistance as set forth in §51014.2(b), (c), and (d) pending a hearing decision shall be provided if the beneficiary appeals in writing to the Department for a hearing within 10 days of the mailing or personal delivery of the notice of action pursuant to §51014.1(c), (e) or (f), or before the effective date of the action. (§51014.2(a))

In the case of a termination or reduction pursuant to §51014.1(c), authorization shall be maintained until the period covered by the existing authorization expires, the date a hearing decision is rendered, or the date on which the hearing is otherwise withdrawn or closed, whichever is earliest. (§51014.2(b))

404-5
Effective July 1, 2001, persons who are discontinued from CalWORKs and remain eligible for Medi-Cal under §1931(b) must receive a Notice of Action (NOA) containing certain information. Persons who are no longer eligible for §1931(b) but are eligible for another Medi-Cal program must receive an NOA with the name of the program to which they have been transferred, and a description of that program.

These NOAs must also contain the following information:

1. A statement that receipt of Medi-Cal benefits is not counted against CalWORKs time limits.

2. A statement that monthly or quarterly status reports are not required, except for an annual redetermination form (and Transitional Medi-Cal forms, where applicable); however, significant changes that may affect eligibility or share of cost must be reported by the beneficiary within ten days.

3. The eligibility worker's name, telephone number, and hours.

If the eligibility worker has been reassigned, the county must notify the beneficiary within ten days of the reassignment of the new worker's name, address, telephone number, and the hours during which an eligibility worker can be contacted. Counties may use the office hours or the worker's core hours.

Counties may continue to use the existing §1931(b) Approval NOA (MC 339) for all persons who are not discontinued CalWORKs persons. Counties should use the §1931(b) Denial or Discontinuance NOA (MC 340) for former CalWORKs persons who are discontinued from §1931(b) or for non-CalWORKs persons who are applying for Medi-Cal, but determined not eligible. These and other NOAs will be modified to include worker hours and reporting requirements.

(All-County Welfare Directors Letter (ACWDL) No. 01-17, February 27, 2001, implementing Senate Bill 87, Ch. 1088, Stats. 2000, and referencing ACWDL No. 96-56)

404-6
Prior to 1994, all Medi-Cal beneficiaries received a paper Medi-Cal card for each month in which the beneficiary was eligible. In 1994, the Department of Health Services (DHS) began converting from paper Medi-Cal cards to the plastic Benefits Identification Card (BIC). Using the BIC, a provider can verify the beneficiary's Medi-Cal eligibility through the Point of Service (POS) Network. A new card is no longer issued to every Medi-Cal eligible person on a monthly basis. (All-County Welfare Directors Letter (ACWDL) No. 96-06, February 1, 1996)

As of June 1, 1997, both Medi-Cal cards, and the Form MC-177, had been eliminated and had been replaced by the BIC system. (Denti-Cal Bulletin, Vol. 13, No. 13, June 1997)

One of the advantages of paper cards was that the card itself was Proof of Eligibility (POE) and anything that happened during the month (such as a hold) had no effect on the card's validity. A problem with the BIC system is the impact of MEDS (Medi-Cal Eligibility Data System) generated holds. These MEDS holds are often caused by edits on data received from counties. Edits within MEDS can cause a system-generated hold or termination. When a provider attempts to verify eligibility on a beneficiary that is on a MEDS hold, a message of "no recorded eligibility" (ineligible) is received and services are often refused. In effect the beneficiary will have lost eligibility without the required ten-day notice.

The terms of the *Burman* v. *Belshé* settlement include modifying MEDS so that beneficiaries will not have their Medi-Cal eligibility status changed without proper notification (i.e., ten-day notice). In other words, MEDS generated holds and terminations will no longer impact eligibility, and eligibility will continue until the county welfare department resolves the hold/termination or terminates the eligibility with prior notification.

(ACWDL No. 96-06, referencing *Burman* v. *Belshé*)